

Life after Economic Triage

October 3 marked a watershed in the country's financial history, when the House of Representatives voted 263 – 171 to approve the Emergency Economic Stabilization Act. The House vote came 48 hours after the Senate's approval and just days after the House had rejected an earlier version of the sweeping financial bailout program.

As difficult as it was to muster the necessary votes, working out the details of the financial rescue legislation may have been the easy part. By the time the plan is fully implemented, lawmakers who survived their election campaigns will return to Washington to face a landscape that is dramatically different and a fiscal situation so limiting, every decision will be made in a new context. The key aspects of the legislation are:

- Establishment of a Troubled Asset Relief Program (TARP) to purchase holdings from financial institutions through a new Treasury Department program, the Office of Financial Stability. TARP will be run in consultation with the Federal Reserve Board of Governors, the FDIC, the Comptroller of the Currency, the Office of Thrift Supervision and the Department of Housing and Urban Development.
- TARP would initially be capitalized with \$250 billion. The President may certify the need for an additional \$100 billion, but the remaining \$350 billion becomes available only if the President sends a written request to Congress, and lawmakers approve the request.
- The President is required to submit legislative proposals designed to capture any taxpayer losses by assessing participating organizations after five years of operation.
- The Treasury Department will receive non-voting stock warrants from participating organizations, establish an insurance program for those entities and assess risk-based premiums based on the assets held by those organizations.
- Institutions that participate in the program must agree to limitations on executive compensation and severance packages for executives.
- FDIC insurance limits are increased from \$100,000 to \$250,000 per account, through December 2009.

The next several weeks and months are certain to change the financial market's landscape, both here and abroad, as the Treasury Department sets out the rules for executing the TARP program.

Reckoning and reconciling

In the meantime, the events of the last several weeks, including mergers of some heretofore venerable financial institutions, have shaken the public's confidence and have changed the dynamics in political campaigns throughout the country. Candidates who campaigned on big ideas and ambitious plans for stabilizing entitlements, improving national security and reforming the nation's health care system are being forced to downsize those plans to accommodate some long-overdue scrutiny to the culture of borrowing that has driven the actions of government and its citizens alike.

The result will most likely be a degree of austerity not seen for a very long time. The pitched battles over spending priorities that stalled appropriations bills for the past two years, for example, may look like petty squabbles by comparison.

The bailout plan to shore up—and sober up—financial markets will leave the federal budget with a hangover for years to come. If the entire \$700 billion authorized in the rescue plan is committed, the federal debt will grow as much in 2009 as it has in the previous three years combined.

Even before the current financial crisis, government spending was outpacing revenues. The Congressional Budget Office has estimated that for the fiscal year that just ended on September 30, the federal deficit had grown to a record high \$438 billion—a level the experts did not think would be reached until next year. Included in the mix are \$441 billion in interest payments to Wall Street and foreign governments that have lent to the US and to the trust funds that finance Medicare and Social Security.

While the federal government is clearly over-leveraged, some economists say the deficit is manageable, noting that when measured as a percentage of gross domestic product the red ink accounts for only about three percent of GDP, less than the deficits of the early and mid-1980s. Many argue that now, more than ever, is the time for an economic stimulus package, focused primarily on infrastructure spending, public housing, energy and job training programs.

In late September, a \$50 billion stimulus bill died in the Senate, when Republicans threatened a filibuster. But Democratic leaders may attempt to revive the legislation, either during a post-election lame-duck session or in early 2009. The Speaker of the House, Nancy Pelosi, and her Senate counterpart, Harry Reid, have recommended calling Congress back into session in November to consider a \$150 billion economic stimulus package, although no final decision has been made.

Appropriations in limbo

Just before the start of fiscal year 2009, lawmakers raced to pass an enormous stopgap spending bill, a continuing resolution that would keep the federal government operating until March 6.

The CR as it is called contains three security-related appropriations bills—Defense, Homeland Security and Military Construction-Veterans Affairs. Spending for the remaining nine appropriations bills would be held at fiscal 2008 levels until a new president and a new Congress have an opportunity to decide how to proceed.

Discretionary spending for the three appropriations bills totals nearly \$601 billion, or about 60 percent of total discretionary spending. (Of the three bills, only the Military Construction-VA legislation was debated on the floor of the House.)

As for the remaining bills, congressional staff is working behind the scenes while lawmakers are home campaigning, in an attempt to clear the way for quick action when the 111th Congress convenes in January.

Making the case for health care reform

Even though the growing federal deficit and the financial crisis will force the next president to rein in spending, the worsening economy creates even more pressure on government to pass sweeping changes to the U.S. health care system.

Both presidential candidates have offered health care reform plans of very different varieties; both have gained significant media coverage. Often overlooked, however, is the fact that any proposal must go through the gauntlet of congressional review, where the operational details have to be ironed out.

With that in mind, Senate Finance Committee Chairman Max Baucus (D-MT) continues to lay to the groundwork for a 2009 health care reform initiative, with intentions to announce basic reform principles in late November. Although plans are still very preliminary, within the past year Senator Baucus has convened eight

hearings on health reform as well as a one-day health summit for members of Congress. He has explored the gamut of issues including cost-containment, delivery system reform and improved quality, payment reform including pay-for-performance and/or a bundled system as well as health information technology and comparative effectiveness.

Regardless of the shape reform legislation ultimately takes, Congress will have to deal with two major initiatives left hanging when it adjourned: reauthorizing the State Children's Health Insurance Program (SCHIP) and permanent reform to the Medicare physician payment system. SCHIP will have to be addressed early in 2009 because the current statute expires in March, while the temporary patch to the physician payment formula runs out at the end of 2009.

Comparative effectiveness research draws spotlight

As Baucus and others look ahead to the health reform debate, some of their attention is focused on the potential dividends of comparative effectiveness research.

While almost no one disputes the basic goal behind comparative effectiveness research—measuring and reporting on both the clinical effectiveness and cost effectiveness of drugs and treatments—fractures emerge when policymakers start talking details.

Health care experts have said that this research is essential to controlling costs and covering the uninsured, and holds the potential to improve the quality of care patients receive. Congressional Budget Office Director Peter Orszag estimated that the United States could save up to \$700 billion annually in health spending by identifying treatments that do not produce the best medical outcomes.

No one will argue against reducing costs, encouraging doctors to use the best value treatments and medicines and providing patients with more information about treatment options, but there are two fundamental questions to be answered: Should a comparative effectiveness institute be part of government agency and should the program be focused on clinical effectiveness or saving costs?

As for the first question, many have advocated that the Agency for Healthcare Research and Quality (AHRQ) is best suited to take on this effort because it has a track record in this field of study. Along those lines, last year the House passed legislation that would have assigned AHRQ responsibility for conducting, supporting and widely disseminating the findings of comparative effectiveness research. But others argue that research findings should be insulated from political pressure, noting that in the past, federally-funded research programs have been slashed when findings have discredited a lucrative treatment. In response to that criticism, Senator Max Baucus and Senate Budget Committee Chairman Kent Conrad (D-ND) have introduced legislation that would create a public-private institute to foster comparative effectiveness research.

In support of his legislation, Baucus said that “we should devote more than one-tenth of one percent of health spending to study how well health goods and services actually work.” Currently, the federal government only spends \$15 million to compare the effectiveness of treatments.

However, whether this research is focused on clinical effectiveness or cost effectiveness remains a point of contention. Proponents say that significant health savings will surface when providers follow the recommendations that emerge from this research. Others argue that comparative effectiveness research should focus on comparing clinical outcomes, not cost-effectiveness, and concentrate on scientific research, not budget policy.